Kentucky Department for Medicaid Services

Drug Review Options

The following chart lists the drug classes scheduled for review at the July 17, 2003, meeting of the Pharmacy and Therapeutics Advisory Committee and options that were submitted for review.

Drug Class	Options for Consideration
Hepatitis C Therapy (Pegylated Interferon-alfa, Ribavirin)	Pegasys and Peg-Intron are clinically equivalent and are similar in cost. Rebetol and Copegus are also clinically equivalent but Copegus is lower in cost as determined by AWP. Options: 1. Duration of Therapy Limit on Peginterferon and Peginterferon plus Ribavirin of 12 weeks for initial treatment. For renewal after 12 weeks require evidence of a minimum 2-log decrease in viral load as determined by HCV RNA assay at 12 weeks. For viral genotypes 1 and 4 continue treatment for additional 36 weeks (total of 48 weeks) and for viral genotypes 2 and 3 continue treatment for additional 12 weeks (total of 24 weeks). 2. Prefer Copegus brand of ribavirin and require PA for Rebetol.
Class Review of Antiemetic Agents to Treat Severe Nausea / Vomiting (Serotonin 5-HT3, Emend)	Recommendations for the Serotonin 5-HT3 antiemetics and Emend are: 1. Quantity limits (No PA) – Place quantity limits on the 5-HT3 antagonists and on Emend with the quantity limits based on the average quantity per treatment session (and "X" number of sessions per month), and on available package size of each product. Requests for higher doses would require PA. The following are suggested quantity limits based on three cancer treatment cycles per month and adjusted for available package sizes. Zofran : 4mg and 8mg: 9 tablets per month 24mg: 3 tablets per month Liquid: 50ml/month Injection: 3 vials 20ml (40mg); and 6 vials 2ml (4mg) Kytril: 1mg tablets: 6 tablets per month Liquid: 30ml/month Injection: 6 vials 1mg/1ml Anzemet: 50mg and 100mg tablets: 5 tablets per month Injection: 3 vials 100mg/5ml; and 6 ampules 12.5mg/0.625ml Emend: 3 Tri-packs (9 tablets) per month

	* OR * 2. PA required. Approval based on stated chemo agent and/or type of radiation. Quantities restricted to those mentioned in guidelines above and number of requested cancer treatments per month. Non-oncology use will be approved on an individual basis based on prior use of first-line antiemetics.
Utilization review of the Non-Steroidal Anti-Inflamatory Drugs (Not the Cox-IIs)	The following modification to the NSAID PDL is suggested for the committee's consideration: Make the following products PREFERRED and place them on the Preferred Drug List with the brand name requiring a prior authorization when generic is available. <u>Immediate Release Dose Forms</u> Diclofenac sodium (Voltaren) Etodolac (Lodine) Fenoprofen (Nalfon) Flurbiprofen (Ansaid) Ibuprofen (Motrin) Indomethacin (Indocin) Ketoprofen(Orudis) Meclofenamate (Meclomen) Naproxen (Anaprox, Naprosyn) Oxaprozin (Daypro) Piroxicam (Feldene) Sulindac (Clinoril) <u>Extended Release</u> • Indomethacin SR (Indocin SR) • Naproxen (EC Naprosyn) Make the following products NON-PREFERRED DRUGS and require a prior authorization for their use. <u>Immediate Release Dose Forms</u> Ketorolac (Toradol) Mefenamic Acid (Ponstel) Meloxicam (Mobic) Nabumetone (Relafen) Tolmetin (Tolectin) Diclofenac Potassium (Cataflam) Diclofenac sodium/Misoprostil (Arthrotec) <u>Extended Release Dose Forms</u> • Diclofenac SR (Voltaren XR) • Etodolac SR (Lodine XL) • Ketoprofen SR (Oruvail) • Naproxen (Naprelan)